		HAND HUMAN SERVICES	15th	0131111	FORM	0: 11/17/201 MAPPROVE	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE S		
		445114	B. WING _		11/	16/2011	
	PROVIDER OR SUPPLIER BILL NURSING HOME	INC.	5	REET ADDRESS, CITY, STATE, ZIP C 837 LYONS VIEW PIKE (NOXVILLE, TN 37919			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETION DATE	
F 000	INITIAL COMMENT	TS .	F 000		.0		
	complaint survey #2 November 14-16, 2 Home, no deficience complaint under 42 Requirements for Lo 483.20(g) - (j) ASSE	011, at Brakebill Nursing ies were cited in relation to the CFR PART 482.13, ong Term Care.	F 278				
	resident's status.	ust accurately reflect the					
	each assessment w participation of healt	ith the appropriate					
	A registered nurse nassessment is comp	nust sign and certify that the pleted.					
	Each individual who assessment must sign that portion of the as	completes a portion of the gn and certify the accuracy of sessment.					
	willfully and knowing false statement in a subject to a civil mor \$1,000 for each assewillfully and knowing to certify a material a	Medicaid, an individual who ly certifies a material and resident assessment is ney penalty of not more than essment; or an individual who ly causes another individual and false statement in a is subject to a civil money han \$5,000 for each					
	Clinical disagreemen material and false sta	t does not constitute a atement.					
BORATORY		R/SUPPLIER REPRESENTATIVE'S SIGNAL		Son actministra		X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPAR	FORM	PRINTED: 11/17/20					
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION DING	(X3) DATE S		
		445114	B. WING	i	11/	16/2011	
	PROVIDER OR SUPPLIER BILL NURSING HOME	INC.	s	STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	by: Based on medical rithe facility failed to or Minimum Data Set (in the resident's fall state thirty-three residents. The findings include. Resident #20 was acceptuary 28, 2011, with Stage Chronic Obstroute September 28, 2011, with Medical Record reviews September 22, 2011 mildly cognitively improved by the supervision with ambiguary supervision with ambiguary supervision with ambiguary supervious MDS assess. Medical record reviews July 27, 2011, reveal that date at 1:40 a.m. emergency room for returned to the facility with no new treatmer Emergency Room (Esignificant injury. Medical record reviews Medical record reviews MDS assessing that the facility with no new treatmer Emergency Room (Esignificant injury.	record review and interview complete an accurate (MDS) assessment to reflect atus, for one resident (#20) of s reviewed. ed; admitted to the facility on with diagnoses including End tructive Pulmonary Disease, tory of Trans-Ischemic al Vascular Accident. iew of the MDS dated 1, revealed resident #20 was paired and required bulation and limited staff insfers. The MDS also in had no falls since the issment dated June 29, 2011. ew of a nurse's note dated alled resident #20 had a fall on in., and was transported to the revaluation. The resident to the revaluation. The resident to the revaluation revealed no in the diagram of the progress and physician's progress	F 27	What corrective action will be accorded for resident #20 found to have affected deficient practice, that facility fails that resident was properly assessed documented correctly on MDS for MDS coordinators were verbally that they are to assess and capture accurately on all MDS's. How the facility will identify other having the potential to be affected deficient practice that facility fails and capture falls on MDS. All rest the potential to be affected. Facility the nurse that audits charts check a reviews charts that falls are documented manager. What measures will be put into plat that the deficient practice does not nurse chart auditor will check bisafalls are captured properly on MDS. What measures will be put into plat that the deficient practice does not nurse chart auditor will check bisafalls are captured properly on MDS. How the corrective action will be a to ensure that the deficient practice recur. The nurse chart auditor will findings with MDS nurses bisannum will report findings in QI bisannua then yearly. QI team consists of MDirector, DON, ADON, Nurse Chambos Coordinators, Activity Director, DON, ADON, Nurse Chambos Coordinators, Activity Director, Social Services, Houseke Supervisor, Maintenance Supervisor, Maintenance Supervisor, Maintenance Supervisor, Consulting Pharmacist.	ected by the led to ensure id and refalls. The inserviced is all falls er residents by the ed to assess sidents have ity will have as shemented on acce to ensure threat recur. The innually that S. monitored is does not address her fally and ally times 2, dedical art Auditor, etor, Rehabital Records eeping		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	D: 11/17/201 M APPROVEI
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE	O. 0938-039 SURVEY PLETED
		445114	B. WIN	IG		111	/16/2011
	PROVIDER OR SUPPLIER BILL NURSING HOME	INC.		583	ET ADDRESS, CITY, STATE, ZIP CODE 37 LYONS VIEW PIKE IOXVILLE, TN 37919		10/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 315 SS=D	2011, also indicated that date and was trevaluation. Interview with the M November 16, 2011 office, confirmed the documentation of a captured on the nex September 22, 2011 Interview with the Di November 16, 2011, confirmed the July 2 had not been captur was inaccurate. 483.25(d) NO CATH RESTORE BLADDE Based on the resider assessment, the facinesident who enters indwelling catheter is resident's clinical concatheterization was rewho is incontinent of treatment and service infections and to rest function as possible. This REQUIREMENT by:	investigation dated July 27, de the resident had fallen, on ransported to the ER for IDS Coordinator, on I, at 9:40 a.m., in the MDS as medical record included fall that had not been at MDS assessment dated 1. irector of Nurses (DON) on I, in the conference room also 27, 2011, fall for resident #20 and the MDS assessment HETER, PREVENT UTI, ER int's comprehensive fallity must ensure that a the facility without an is not catheterized unless the indition demonstrates that the necessary; and a resident if bladder receives appropriate the ses to prevent urinary tract tore as much normal bladder. T is not met as evidenced	F 21		DEFICIENCY)		
	and interview the fact bladder continence re	ecord review, observation, sility failed to re-assess etraining for one (#8) and essess one (# 22) for bladder					

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 11/17/2011 MAPPROVED D: 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A BUILDING		SURVEY LETED
		445114	B. WING		11/	16/2011
	(EACH DEFICIENCY	INC. TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		REET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION HOULD BE	(X5) COMPLETION DATE
	The findings included Resident #8 was ad 15, 2011, with diagn Disease, Respirator The resident was reconstructed at June 2, 2011, problem with cognitic continent of bladder. Data Set dated Noveresident required limmaking, had short the was frequently inconstructed in the hosp with diagnoses of Alt Urinary Tract Infections re-admitted to the fact with a Urinary Cathet Medical record review dated October 24, 20 (Discontinue)Cathet sheet dated October urinary catheter was Review of the medical documentation the black of the side of the medical documentation the black of the medical documentation	mitted to the facility on July oses including Bi-Polar y Failure, and Dysphagiaadmitted on October 10, s including Altered Mental ract Infection. w of the Minimum Data Set revealed the resident had no on or memory, and was Review of the Minimum ember 2, 2011, revealed the ited assistance with decision rm memory problems, and tinent of bladder. w revealed the resident was ital on September 19, 2011, ered Mental Status and in. The resident was cility on October 10, 2011, er. w of a Physician's Order 11, revealed, "DC ter". Review of a treatment 24, 2011, revealed the removed. all record revealed no adder assessment had been rinary catheter was removed		What corrective action will be acted for residents #8 and #22 found to affected by the deficient practice failed to reassess resident after recatheter and that resident #22 was accurately assessed for bladder coadmission. All nurses were inser November 16, 17, and 18th, how to assess bowel and bladder on adm. How the facility will identify other having the potential to be affected deficient practice that facility fails bowel and bladder accurately. All have the potential to be affected. Coordinator will assess resident's bladder habits quarterly and initial bowel and bladder assessment if now that measures that will be put intensure that the deficient practice defected. The MDS Coordinators will residents quarterly for changes in the bladder habits and initiate new meanimediately. The CNA will be instituted in the corrective action will be not one catheter removal to toilet receiver two hours or on resident requirements and they will report in QI bitimes 2 and then yearly. QI team of Medical Director, DON, ADON, Now Auditor, MDS Coordinators, Activic Director, Rehab Manager, Dietary Medical Records Director, Social Schousekeeping Supervisor and Main Supervisor, and Consulting Pharmas	chave been that facility emoval of s not ontinence on viced on to accurately ission. The MDS is bowel and the a new seeded. To place to loses all bowel and assures structed at esident uest. The monitored will not assess all ladder annually onsists of urse Chart ity Manager, ervices, tenance	

		H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	D: 11/17/2011 MAPPROVED D: 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445114	B. WING _		11/	16/2011
NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		10/2011
BRAKEE	BILL NURSING HOME	INC.	81	8837 LYONS VIEW PIKE KNOXVILLE, TN 37919		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 315	Continued From pa	ige 4	F 315			
	2011, at 9 a.m., reveled, in the resident time, revealed the resident time, revealed the resident to time and place. Interview with the resident time, revealed, "Interview with the resident to time and place. Interview with the resident time, revealed, "Most of the go to the bathroom, revealed, "Most of the go to the bathroom, Interview with a Reg November 14, 2011 station, confirmed the removal of the removal of the removal of the removal of the confirmed with the MC Coordinator on Novin the MDS Office, rea Urinary Continence.	terview on November 14, realed the resident lying in 's room. Interview, at that resident was alert and oriented esident on November 14, in the resident's room, he time, I know when I have to but I can't hold it sometimes." gistered Nurse (#1) on , at 1:15 p.m., at the nursing he resident had not been dider continence training after urinary catheter on October inimum Data Set (MDS) ember 15, 2011, at 9:30 a.m., evealed the facility completes e Assessment on admission asments are completed.				
	Resident #22 was a October 21, 2011, w Dementia, Chronic I Congestive Heart Fa					
		w of the Minimum Data Set 011, revealed the resident ent of bladder.				
	Medical record revie	w of the nurse's note dated				

FORM CMS-2567(02-99) Previous Versions Obsolete

October 21, 2011, revealed, "...incont (incontinent) B/B (bowel/bladder) (with) perineeds

Event ID: BIY611

Facility ID: TN4702

If continuation sheet Page 5 of 13

PRINTED: 11/17/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445114 11/16/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE BRAKEBILL NURSING HOME INC. KNOXVILLE, TN 37919 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 315 Continued From page 5 F 315 met per staff..." Medical record review of the initial urinary continence assessment dated October 21, 2011, revealed, "...Is the resident continent? If yes do not proceed with assessment ... " (marked yes) Interview on November 16, 2011, at 8:55 a.m., with RN (Registered Nurse) #1, at the nursing station, confirmed the urinary continence assessment was inaccurate. F 323 483.25(h) FREE OF ACCIDENT F 323 SS=D HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards What corrective action will be accomplished as is possible; and each resident receives for resident #21 found to be affected by the adequate supervision and assistance devices to deficient practice that facility failed to apply prevent accidents. lap belt correctly. The LPN who surveyor reported this to immediately applied lap belt correctly and instructed CNA in proper technique of applying lap belt properly. This REQUIREMENT is not met as evidenced How the facility will identify other residents

FORM CMS-2567(02-99) Previous Versions Obsolete

The findings included:

reviewed.

Based on medical record review, review of the

application instructions for a lap belt, observation,

and interview, the facility failed to ensure a safety

resident, failed to provide supervision to prevent

an accident for two (#1, #16) residents and failed to ensure a mechanical lift was used to prevent

an accident for one (#3) of thirty-three residents

Resident #21 was admitted to the facility on

device was applied correctly for one (#21)

Event ID: BIY611

Facility ID: TN4702

physical therapist.

having the potential to be affected by the

deficient practice of improperly applying lap

instructed quarterly with inservice by physical

What measures will be put into place to ensure

that the deficient practice does not recur. All

staff will be inserviced and will demonstrate proper application of all lap belts quarterly by

therapist on proper application of restraints.

belts will not recur. All residents have the

potential to be affected. All staff will be

If continuation sheet Page 6 of 13

		AND HUMAN SERVICES): 11/17/201 // APPROVEI
STATEMEN	TOF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	TIPLE CONST	TRUCTION	(X3) DATE S	
		445114	B. WING			111	16/2011
	PROVIDER OR SUPPLIER BILL NURSING HOME	INC.	STREET ADDRESS, CITY, STATE, ZIP COI 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919			11/16/2011 DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORE ACH CORRECTIVE ACTION S SS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Presenile Dementia Osteoporosis. Medical record reviet dated October 12, 2 regular w/ch (wheeld Review of the applicate belt/padded lap belt of the connecting strangle between the sidescriss-cross the draw them around the Observation on Nove with LPN (Licensed I resident's room, revewheelchair, with a furth observation revealed between the wheelch left strap around the criss-crossed behind opposite side kick spunder.	wheelchair side and seat, and the right strap of the lap belt in place. Continued the right strap of the lap belt wheelchair side and seat, and the wheelchair side and seat, and the wheelchair seat and the view of the resident seat and the wheelchair seat and the wheelchair seat and the wheelchair seat and the wheelchair seat and the resident seated in a lill ap belt in place. Continued the right strap of the lap belt sair side and seat, and the wheelchair side post, straps the chair and around the urs.	F 32	recur. In quarterly The DO! QI times QI team ADON, Coordina Manager Director, Supervise	e corrective actions will le that the deficient practions will be documed and kept on file at nurs. Nor ADON will report is 2 bi-annually, then year consists of Medical Directors, and Consists of Medical Directors, Activity Director, point of Services, Housel or and Maintenance Suping Pharmacist.	ice does not ented sing home. inservices in rly thereafter. ector, DON, DS Rehab lical Records keeping	J2-J-J1
	December 31, 2009, Cerebrovascular Dise Hypertension. Medical record review dated October 13, 20	nitted to the facility on with diagnoses including ease, Diabetes, and of the Minimum Data Set 11, revealed the resident sistance with two plus		for resider deficient p maintain s transferred person ass Resident v all transfer	rective action will be account #1 found to be affecte bractice that facility faile safety with transfers. CN d resident with gait belt a sist, resulting in assisted was to have two-person ars. The CNA was verbaby the charge nurse at the	ed by the ed to NA and one fall. assist with	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/17/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		445114	B. WIN	۷G _		11/	16/2011
	PROVIDER OR SUPPLIER	INC.		5	REET ADDRESS, CITY, STATE, ZIP CODE 837 LYONS VIEW PIKE (NOXVILLE, TN 37919	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Medical record revious Cotober 2011, reverting transfers" Medical record revious Cotober 21, 2011, reverting assisted in a lostbalance and version CNA (certified nurs presentno eviden noted" Interview on Novem with the Director of station, confirmed the person physical assisted assisted in a lostbalance and version confirmed the person physical assisted assisted assisted the person physical assisted as a lost Resident #3 was regularly 13, 2010, version physical assisted August 28, 20 scored 13 out of 15 Medical record revied dated August 28, 20 scored 13 out of 15 Mental Status (cogniassistance of two person thad any falls sin Medical record revied dated January 13, 2 (mechanical lift used for all transfers"	ew of the care plan dated caled, "assist x 2 with all ew of the nurse's note dated revealed, "Resident was transfer from gerichair to bed, was assisted to the floor by a ing assistant) with gait belt ce of bruising or injury aber 15, 2011, at 7:50 a.m., Nursing, at the nursing he resident required two sistance for transfers. -admitted to the facility on with diagnoses including, Intervertebral Disc	F3	7.71	How the facility will identify other thaving the potential to be affected by deficient practice that facility failed maintain resident safety while being transferred. All residents have the pube affected. All staff will be inserving proper transfers and how to check pube care/kardex for number of people neutransfers. What measures will be put into place that the deficient practice does not restaff will be inserviced quarterly on transfers and how to check plan of conformation for number of people needed for transfers and the deficient practice of the ensure that the deficient practice of recur. Inservices on proper transfers kept on file at nursing home. The Deficient practice in QI but times two, then yearly. QI team conformed to make the proper times transfers to the proper times that the position of the proper times that the proper times that the deficient practice of the proper transfers that the deficient practice of the proper times transfers that the deficient practice of the proper times that the proper times transfers that the deficient practice of the proper transfers that the deficient practice of the proper transfers that the deficient practice of the proper times that the deficient practice of the proper transfers that the deficient practice of the proper transfers that the deficient practice of the proper transfers that the deficient practice of the proper times that the	y the to g cotential to ced on lan of eeded for e to ensure ecur. All proper are/kardex asfers. conitored does not s will be ON or oi-annually asists of rse Chart y fanager, rvices, nce	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING

PRINTED: 11/17/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 00000000	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		445114	B. WIN		11/	16/2011	
BRAKE	PROVIDER OR SUPPLIER BILL NURSING HOME	E INC.		STREET ADDRESS, CITY, STATE, ZIP CO 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919	ODE	10/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	revealed "all transtand" Medical record rev November 6, 2011 x2 (two Certified N transfer resident for (resident) began slowered resident to Medical record revinote dated Novembrouse person transfer from injury" Medical record revinovember 7, 2011, Meetings: on 11-06 transferring res (resident) slowered resident to the facility document at 9:00 a.m., in the confirmed the resident standard resident to the facility document at 9:00 a.m., in the confirmed the resident standard record revinous for the facility document at 9:00 a.m., in the confirmed the resident record revinous formed the resident followed when two the facility document at 9:00 a.m., in the confirmed the resident followed when two the facility document the facility document at 9:00 a.m., in the confirmed the resident followed when two the facility document at 9:00 a.m., in the confirmed the resident followed when two the facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9:00 a.m., in the confirmed the resident facility document at 9	iew of a nursing note dated, at 8:30 p.m., revealed, "CNA urse Aides) attempting to om w/c (wheelchair) to bed iding shoes slippery. CNA's of floor to prevent fall" iew of a physician's progress ber 7, 2011, revealed, "Asked S/P (status post) fall during 2 m chair to bedno acute iew of a progress note dated revealed, "Falls Team 6-11 at 8:30 PM staff sident) from w/c to bed. Resered to floor by staff. No obedlast fall was reported on the re-educated in use of sit rs" Director of Nursing and review fation on November 15, 2011, Medical Records office, ent's care plan was not CNAs transferred the resident it to stand lift, which resulted	F3	What corrective action will be for resident #3 found to be affed deficient practice that facility in maintain safety with transfer. were transferring resident with sit-to-stand lift as ordered and The CNAs were verbally countfall. How the facility will identify of having the potential to be affed deficient practice that facility in maintain resident's safety whill transferred. All residents have be affected. All staff will be in proper transfers quarterly. What measures will be put into that deficient practice does not will be inserviced on proper transfers quarterly and demonstrate transferchniques. How the corrective actions will to ensur that the deficient practice consulting home. The DON or All report inservices in QI bi-annual then yearly. QI team consists of Director, DON, ADON, Nurse MDS Coordinators, Activity Di Manager, Dietary Manager, Med Director, Social Services, Hous Supervisor, Maintenance Super Consulting Pharmacist.	ected by the failed to Two CNAs tout the use of careplanned. seled at time of other residents eted by the failed to the being the potential to diserviced on the potential to diservice on the monitored ice does not by on proper to on file at DON will ally times two, of Medical Chart Auditor, irector, Rehabedical Records ekeeping	12-1-11	

		H AND HUMAN SERVICES 8 MEDICAID SERVICES			FORM	D: 11/17/2019 MAPPROVED D: 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S	SURVEY
		445114	B. WING		11/	16/2011
	PROVIDER OR SUPPLIER BILL NURSING HOME	INC.		TREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 9	F 323	3		
	October 17, 2007, v Dementia, Chronic of history of falls. Medical Record Rev Assessments dated October 20, 2011 re intermittent confusion ambulatory with balaresident takes multiple falls risks. Resident risk for falls. Medical record reviet (MDS) assessment revealed resident #1 assistance with trans Medical record reviet October 21, 2011, re the assistance of two Continued care plant 8, 2011, revealed the supervision with toiled Review of a facility of 2011, revealed resident released the resident and "was called av resident to the toilet dementia and no saf	ance disturbances, and the iple medications that elevate it #16 was assessed as high ew of a Minimum Data Set dated October 20, 2011, 16 required extensive asfers and locomotion. The work of a care plan dated evealed the resident required to staff for all transfers. In review of an entry date April e resident required direct eting. The documentation dated June 7, dent #16 fell, when a CNA lent to the bathroom alone, int's lap belt (safety device), way before helping theRes (resident) has fety awareness" The an unassisted/unsupervised		What corrective action will be accomfor resident #16 found to be affected deficient practice that facility failed to maintain resident safety while being Resident left unattended and required supervision of toileting needs. Reside to emergency room for evaluation. To was terminated. How the facility will identify other rehaving the potential to be affected by deficient practice that facility failed to maintain safety for resident during to All residents have the potential to be All staff will be inserviced on supervesident that requires use of restrictive when out of bed. CNA's employment result in terminiation if they fail to cowith proper supervision. What measures will be put into place that the deficient practice does not restaff will be inserviced quarterly on proper supervision for all residents unrestrictive and/or safety devices when toileted. The staff will be told if they comply with proper supervision, term of employment may result.	by the to toileted. d dent sent The CNA esidents y the to oileting. affected. vising any we device nt may comply et to ensure secur. All providing sing n being y fail to	12-1-11

Interview with RN #3, Green Hall (300 hall)

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION	(X3) DATE S COMPLI	
		445114	B. WIN	IG_		11/1	6/2011
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	• • • • • • • • • • • • • • • • • • • •	0/2011
BRAKE	BILL NURSING HOME	INC.		5	837 LYONS VIEW PIKE (NOXVILLE, TN 37919		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441 SS=D	a.m., at the Green I confirmed the reside while toileting as ca requiring an emerge out significant injury. Interview with the D November 16, 2011 conference room co occurred while the resident of the second of	lovember 15, 2011, at 9:45 Hall Nurses Station, ent had not been supervised re planned and suffered a fall, ency room evaluation to rule irector of Nursing (DON) on , at 7:47 a.m., in the enfirmed the June 7, 2011, fall esident was unsupervised. CONTROL, PREVENT ablish and maintain an ogram designed to provide a comfortable environment and levelopment and transmission tion. Program ablish an Infection Control h it - trols, and prevents infections ecedures, such as isolation, an individual resident; and d of incidents and corrective ections. Individual of Infection	F 4	41	How the corrective actions will be not one ensure that the deficient practice recur. Inservices will be kept on file nursing home and terminations will file. The DON and ADON will addinservices and terminations will be not on the QI bi-annually time two, then yearly consists of Medical Director, DON, Nurse Chart Auditor, MDS Coordin Activity Director, Rehab Manager, I Manager, Medical Records Director Services, Housekeeping Supervisor Maintenance Supervisor, and Const Pharmacist. What corrective action that will be accomplished for the deficient practifacility failed to maintain proper infecontrol, evidenced by CNA #2 improfilling ice pitchers. Surveyor reporte LPN #1 and she immediately demonstrate proper technique in filling water pitch hand sanitizing to comply with infection trol. How the facility will identify other rethat have the potential to be affected deficient practice of improper infection control. All residents have the potential fected. All CNAs will be inserviced proper techniques of passing ice/filling pitchers and proper hand sanitizing. What measures will be put into place the deficient practice does not recur. will be inserviced quarterly on proper infection control when filling water pitcherical proper infection control	does not e at be kept on dress reported in v. QI team ADON, ators, Dietary, Social and alting ce that ection operly d this to strated hers and tion residents by the bin cial to be d on ag water to ensure The staff	12-/-//
	communicable disea	se or infected skin lesions ith residents or their food, if		i	and proper handwashing and hand sar	nitizing.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM): 11/17/2011 MAPPROVE	
STATEMEN	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	OMB NO. (X3) DATE SI COMPLE		
		445114	B. WIN	1G _		11/	16/2011	
	PROVIDER OR SUPPLIER BILL NURSING HOME	INC.		5	REET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919		17710/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	direct contact will tra (3) The facility must hands after each dir hand washing is ind professional practica (c) Linens Personnel must han transport linens so a infection. This REQUIREMEN by: Based on observati failed to maintain inf on the Green hallwa The findings include Observation on Nove resident's rooms on a.m., revealed Certif #2, filling ice water p outside of the reside observation revealed resident's room (two the used water pitche rooms, used a scoop the water pitcher, hel the ice chest and fille (pitchers had already without cleaning the se Further observation r	ansmit the disease. I require staff to wash their rect resident contact for which icated by accepted e. Indie, store, process and as to prevent the spread of the prevent the spread of the green hallway, at 8:25 and the green hallway, at 8:25 and the contact of the pitchers over the top of the contact of the contact of the pitchers with ice of the contact of the c	F 4	41	How the corrective actions will be to ensure the deficient practice will Staff will be inserviced quarterly of control and proper handwashing an sanitizing when filling water pitche quarterly. Will be addressed in QI ADON bi-annually times 2, then yet team consists of Medical Director, ADON, Nurse Chart Auditor, MDS Coordinators, Activity Director, Re. Manager, Dietary Manager, Medical Director, Social Services, Housekee Supervisor and Maintenance Superv Consulting Pharmacist.	I not recur. In infection and the sers by DON or early. QI DON, I hab	12-1-1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BIY611

Facility ID: TN4702

If continuation sheet Page 12 of 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/17/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445114	B. WII	NG		11/16/2011	
	PROVIDER OR SUPPLIER BILL NURSING HOME			583	ET ADDRESS, CITY, STATE, ZIP CODE 37 LYONS VIEW PIKE IOXVILLE, TN 37919		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	at 8:27 a.m., in the pitchers had been used pitchers were the ice chest and the when placed inside interview confirmed the hands between Observation and int Nurse (LPN) #1, the November 15, 2011 confirmed the used over the ice chest, the when placing ice interview and the CNA did no resident's rooms. Further thanks the confirmed the co	# 2, on November 15, 2011, hallway, confirmed the used by the residents, the filled with ice over the top of the scoop was contaminated with water pitchers. Further the CNA had not sanitized	F	141			